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HEALTH CARE OF CLERGY AND RELIGIOUS

JAMES T. NIX, M.D., Ph.D., K.S.G.*

THE HEALTH of religious is a matter of grave concern to the Church, and more particularly to those religious superiors directly charged with guarding the physical well-being as well as the spiritual growth of individuals in their care. Much emphasis has been placed on plant maintenance, yet little has been done to further the usefulness of our much needed and limited number of religious personnel. Although recent medical advances have resulted in an improvement in the health of religious, a modern health program would further reduce morbidity, and increase the productivity and longevity of religious personnel.

At the request of Reverend John J. Flanagan, S.J., Executive Director of The Catholic Hospital Association, Dr. William J. Egan, President of the National Federation of Catholic Physicians' Guilds, in 1959, appointed a Committee on Medical Care of Religious. Members of this committee are:

Reverend John J. Flanagan,
S.J., St. Louis, Mo.

Reverend Marvin Bordelon,
Shreveport, La.

Dr. Eusebius J. Murphy,
Bronx, New York

Dr. Alice Holoubek,
Shreveport, La.

Dr. Francis T. Harrington,
Dallas, Tex.

Dr. L. J. Johnston,

Dallas, Tex.

Dr. William J. Egan,
Brookline, Mass.

Dr. J. T. Nix, Chairman,
New Orleans, La.

The committee's scope includes both long-range and immediate objectives, and envisages a pilot study as an initial step in evaluating a standardized and effective health program for religious.

OBJECTIVES

The long-range objectives of the Committee on Health of Clergy and Religious include:

1. National survey on health of clergy and religious with emphasis on:
 - a. Disease incidence
 - b. Occupational disease
 - c. Community rules
 - d. Specific diseases
 - e. Overwork
2. Organization of community physicians to obtain pooled experience nationally and co-operation locally.
3. Development of standards for admission as part of a complete record system.

*This preliminary report, presented at the Federation Executive Board Meeting, June 15, 1960, Miami Beach, Florida, was prepared by Dr. Nix, Chairman of the Committee on Medical Care of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and The Catholic Hospital Association.

4. Financing of centrally located national office for a modern health program through public health grant. This would provide for the organization of information as well as a statistical and reference library.

5. Supervision of education of each of the following groups to bring their specialties in line with the program:

Ancillary personnel (infirmarian, dietitian, nurse, technician)

Community physicians

The immediate objectives of the committee are:

1. Standardization of a preadmission physical with printing and distribution nationally. The form is largely a question and answer type to be filled out by the religious.

2. Establishment of a pilot project, employing the preadmission physical form in selected communities and areas of the United States. It is hoped that the pilot project will make possible the most good for the largest number in the shortest period of time. Furthermore, the experience of community physicians and supervisors in executing the project will prove valuable to correct any defects in the standardized form prior to more widespread distribution. It is hoped that the local Catholic Physicians' Guild in each community will be able to collect necessary statistics to prove the value of the program.

SUGGESTED HEALTH PROGRAM FOR CLERGY AND RELIGIOUS

In the absence of detailed scientific data and until such facts are available, the following pilot program for an initial physical examination and general directives on health are suggested. Major emphasis is placed on the role of the community physician and the necessity for standardized medical records, kept as a continuous index of the health of each member of a religious community. Consideration is also given to disease prevention and treatment.

Community Physician

The community physician must know the personnel, rules, and customs of the community and must have the confidence and collaboration of the superior. He should, if possible, be an active member of the local Catholic Physicians' Guild. He may be a non-Catholic but should be approved by the Chancellor of the diocese.

Individual members of the clergy and religious should have the right to select either a personal physician or the community physician. In any event, the physician of choice should be approved by the Chancellor. This is particularly important in the selection of psychiatric consultants. The community physician should either perform the preadmission physical examination or pass judgment based on the recommendations and findings of the personal physician. He must play a dual role — sharing the confidence of the patient, yet bound as community physician to submit a sincere opinion to the

superior. He is morally and legally obligated not to share the confidence of the individual religious with the superior without the individual's authorization. He should learn from the industrial physician the economics of illness and the significance of religious hours lost. He should profit from the collected experience of others rather than rely solely on his own judgment.

Upon request he should be allowed to question a religious without another fellow religious present. This is particularly important in psychiatric or emotional disturbances.

Admission Physical

Disease in general among the religious could be considerably reduced if standard admission requirements were used to eliminate those physically or mentally unfit for the strain of religious life. At present each community has different medical requirements, and many have practically none at all. Competent medical opinion could help evaluate the suitability of candidates. However, if requirements too severe and inflexible were adopted, many true vocations might be lost. It is always well to bear in mind that the best medical recommendations can never envisage the efficacy of the grace of God.

Admission requirements for religious life should clarify the mandates of Canon Law, should satisfy the requirements of community rules in the specific religious vocation and reflect the experience and recommendations of the community physicians. Gradation of

physical requirements would be necessary, with those for diocesan priests and seminarians the most rigid; as sight, manual dexterity, and vocal inflection are essential for saying Mass and hearing for confession. Admission requirements for missionary and contemplative religious life would need special consideration.

Fingerprint and dental data should be filed locally and centrally, to make physical identification of religious possible and infiltration of religious communities unlikely in the event of a national emergency. The various subspecialties of religious life could be coded by the color of the application sheet and eventually a punch-card system could be used for statistical analysis.

The physical examination portion of the preadmission physical should be performed without charge by either the community physician or the personal physician. However, in deference to possible parental objection, it would seem advisable that the community rather than the individual be responsible for special laboratory studies. In any event, the community superior should make the final decision as to the acceptability of the applicant for religious life. Psychiatric screening would be necessary to decrease the number of breakdowns in religious life. The physical examination should be repeated at the end of the novitiate, prior to entry into full community life.

A standard initial physical examination for clergy and religious has been prepared by the Commit-

tee on Health of Clergy and Religious of the National Federation of Catholic Physicians' Guilds and The Catholic Hospital Association and has been printed by the Association's central office in St. Louis. If used as pre-entrance, complete record should be forwarded to the proper religious superior. If used as initial physical examination for priests, brothers, and sisters, this record should be considered *privileged information* and cannot be *communicated* to any religious superior unless specific *permission* is given by the examinee.

Correctible defects requiring surgery should be attended to preferably prior to admission. The Committee on Health of Clergy and Religious considers that surgical correction of the following operable defects would render the candidate eligible for admission:

- Harelip
- Goitre
- Pilonidal cyst
- Fistula in ano
- Cholelithiasis
- Intervertebral disc rupture
- Ruptured meniscus of knee
- Hernia
- Hydrocele
- Undescended testical
- Phimosis
- Uterine prolapse

Admission Standards

Adoption and distribution of a standard physical examination form and analysis of the findings therefrom must naturally precede development of admission standards.

Health Record System

Widespread use of a health record system would furnish data, including a scientific appraisal of the occupational hazards of religious life. The preadmission physical examination would collect all the past medical history of the individual and supplement this with a complete report on current health. This record should be maintained throughout the entire stay of the member in the community and should be kept in triplicate; one copy to the personal or community physician, one copy to the infirmarian, and the third copy to the central office.

Each local station should have an infirmarian trained in medical records. Possibly, a course could be arranged through the facilities of The Catholic Hospital Association. The infirmarian would be responsible to see that tetanus, polio and smallpox immunizations are kept current. Drug sensitivity, as listed in the history, should prevent needless, allergic reactions to penicillin, antitoxin and other drugs.

The community physician, with the authorization of the individual religious, would provide the superior and the infirmarian data on positive laboratory studies, diagnoses, operations, dietary restrictions and the limitation of activity. This could be done by photostating copies of original laboratory reports and, occasionally, by giving a report to be presented as a summary at the time of transfer to a new station. This would provide the new physician with a record of previous diseases and opera-

tions, would facilitate emergency treatment and would avoid useless, repetitious and expensive diagnostic tests. The new community would be informed of the capabilities of the individual religious and thus better able to control assignment to full or limited duty.

Disease Prevention

Immunization against the following diseases should be provided:

- Tetanus
- Typhoid
- Diphtheria
- Polio
- Smallpox

Revaccination should be done when necessary.

Dress

May need to be altered to suit season and climate, with material nonflammable and style nonrestricting.

Diet

Dietitian for each individual station should be trained through the facilities of The Catholic Hospital Association rather than appointed by the community.

Diet should be adequate to prevent:

- Avitaminosis
- Obesity
- Constipation
- Food poisoning

Provision should be made for special diets, when indicated, as in diabetes and duodenal ulcer. Some prohibitions should be dispensed with to facilitate the treatment of ulcer cases. Feedings between meals and before

Communion should be allowed.
Sleep

Rigid rule of seven hours nightly should be mandatory; not subject to the desires or work load of individual religious.

Individual Routine

Proper health habits should be maintained.

Contagion

Precautions should be observed regarding the possibility of contagion from within and without the domiciles of religious life.

Accidents and Accident Prevention

As novices, postulants and seminarians devote much of their recreation time and energy to sports, fractures and accidental injuries are most common. Sports involving bodily contact should be indulged in only when the participants are properly protected and in good physical condition.

Recreation

A daily allotment in fact rather than in name and an annual allotment of one week in addition to retreat should be mandatory. Vacation facilities on a farm or beach, if possible, would be recommended.

Physical Examination

Physical examination every year for personnel over forty to include chest X-ray, electrocardiogram, urinalysis and hemoglobin. Emphasis should be placed on weight gain to prevent obesity and on adequate special studies because of the

high incidence of cancer. This examination should be repeated prior to advancement to greater responsibility in the community in order that the community protect its investment in superior-executive personnel.

Limited service assignment or compulsory retirement should be applied to personnel upon approval or advice of the community physician.

Treatment

General Principles

The individual religious would have choice of either a personal physician or the community physician. The individual religious should authorize the physician to forward a health report to the superior.

No religious should be allowed to remain in his or her quarters for more than forty-eight hours without seeking medical advice. Prolonged illness should require transfer to the community infirmary or to a hospital.

In matters pertaining to their personal health, superiors should be required to report to a specifically designated member of the community whose recommendations regarding medical care should be accepted as mandatory.

Infirmary Care

Standard floor plans according to purpose of infirmary — *convalescence, rehabilitation, psychiatric or geriatric care* with isolation for contagious disease — should be used.

Infirmary should be trained by

local Catholic hospital in emergency routines for treatment of accidental injuries, burns and ingestion of poison.

Hospital Care

Should be provided preferably in Catholic hospital. Provision should be made for insurance coverage in non-nursing communities. Charges should be at a standard reduction rate. Room accommodations should provide privacy and bath. Private rooms would be preferable. In the case of two or more occupants, the other patients should be religious.

Education

Individual religious occasionally resent physical examination and insist on chest auscultation through the habit. Other religious expect supernatural intervention, neglecting the natural means of treatment.

"Heaven is our home" is often the accepted attitude of religious but does not keep teachers in the classroom.

Undue emphasis on religious orders or directives, that warnings and signals of the body are to be ignored or pushed aside, should be discouraged. *Cancer* does not respect the cloister and a ruptured appendix cannot be sublimated.

It is fair to assume that most communities try to maintain a well-balanced ration between physical and spiritual well-being. However, there are a few who believe physical disease should be ignored or endured.

The health of our clergy and religious is a matter deserving seri-

ous study and more intensive medical research. While conclusive data is not available, it seems safe to predict that the health of the clergy and religious can best be served by a combination of good medical records, adequate care, an interested physician and an alert superior.

In December, 1959, the Committee on Medical Care of Clergy and Religious inaugurated a pilot project in the dioceses of Louisiana. The Catholic Physicians' Guilds of Louisiana tailored their methods to meet the local situation. By way of illustration, as northern Louisiana is predominantly Protestant, many examinations were done by non-Catholic physicians previously instructed by the committee. Without exception, the response of physicians, clergy and religious alike has been most gratifying.

PILOT PROJECT

Education and Orientation

Our prime motive is to develop interest in the Health Program among the clergy and religious as well as physicians. Our educational efforts have included articles in Catholic newspapers, talks before Catholic Physicians' Guilds and hospital groups, and generalized distribution of the health record form to religious communities, individual diocesan Chancery offices, and Catholic physicians. Future issues of THE LINACRE QUARTERLY will contain articles aimed at informing prospective community physicians regarding the aspects of religious life affecting medical care. In addition, Dr. Alice Holoubek of Shreveport pre-

sented the entire program before the International Catholic Doctors Congress held in Munich during July.

Standard Health Record System

The health record of each religious should include a standard preadmission physical examination form, a physician's report sheet and an immunization and morbidity card. The physician's report sheet makes possible rapid communication of essential data to the superior of the individual religious. The immunization and morbidity card was designed by the committee in conjunction with Dr. Constantine J. Fecher to be used both by the pilot project in Louisiana and for his morbidity and mortality studies on a national level. To date sixteen religious communities with provincialates locally, representing twenty-eight hundred clergy and religious, have adopted the health record system for candidates and professed. Annual physical examinations since January, 1960 exceed eight-hundred. In the New Orleans area alone, eighty Catholic physicians have volunteered their services as community physicians. The Program has the approval of the Bishops of the dioceses.

It is our opinion that the preadmission physical and annual check-up forms should be distinct and separate entities. As some of the questions on the form might be misunderstood by the candidate or his or her family, the preadmission form should be given to the examining physician rather than to the candidate. Further-

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more, a most urgent, current need is a method of psychological evaluation.

Our committee hopes to have a revised preadmission physical examination form and a standard record system for new applicants suitable for nationwide use by December, 1960. In subsequent years, our initial national effort will be extended by the addition of programs and procedures already tested in the Louisiana pilot project.

Development of Methods

In New Orleans much thought has been given to coordinating Catholic health facilities and providing channels of communication between the various segments of religious and medical life. Committee consultants have been appointed in the allied fields of medical care (nursing, pharmacy, dentistry, psychiatry, hospital management and pharmaceutical distribution) and in paramedical fields (legal, statistical and clerical). The local committee embraces all recognized medical specialties. Affiliation with a local Catholic hospital as a research center is in process of arrangement in order to obtain grants for research projects and to finance the Program. The names of community physicians, prioresses and superiors are kept current. Additional lists are being compiled of Catholic physicians training religious and non-Catholic physicians treating religious. The provincials of the local

communities are automatically invited to meetings as called.

The constitution and by-laws of the New Orleans Catholic Physicians' Guild were not designed to sponsor and manage efficiently large projects such as the Health Program for Clergy and Religious, along with the Catholic School Health Program. Arrangements are being made with local businessmen to finance offices with central filing and permanent personnel to help administer the Program; \$12,000.00 is to be provided annually.

SUMMARY

To bring consideration of the Health of Religious Program to a close for this issue, it can be stated that effectiveness will be achieved through the following regulations set forth by the committee:

1. The Chancery of the diocese must be kept informed and its approval must be secured prior to the institution of any phase of the Program. This makes for slower but safer progress.

2. The individual religious community is approached through its community physician.

3. All examinations and all phases of the program are voluntary.

4. Each new procedure is tested in one community prior to advocacy of its acceptance throughout a diocese.

AUTOPSY — HOW SOON AFTER DEATH?

JOHN J. LYNCH, S.J.

Professor of Moral Theology, Weston College, Weston, Mass.

WELL KNOWN to doctors generally, and especially abhorred by pathologists, are the medical disadvantages of delaying autopsy unnecessarily. Yet it happens frequently enough, particularly when death has been sudden and unexpected, that delay up to two or three hours is required by Catholic hospital authorities before post-mortem is allowed. And if challenged by staff members for reasons in support of this regulation, more than one administrator is said to invoke section 25 of *Ethical and Religious Directives for Catholic Hospitals*.¹ The directive as worded requires only that "Post-mortem examinations must not be begun until real death is morally certain," and this rule of itself would not ordinarily admit of misunderstanding. But a parenthetical note in fine print, originally appended for reasons to be explained later, is perhaps open to the misinterpretation which suggested the interrogative title under which these comments are made.

The note in its totality reads as follows:

The main point here is that the physician should be reasonably certain that the subject is not merely apparently dead before he starts the post-mortem. More precise information concerning the moment of real death is desirable. Lacking such information theologians usually allow the following intervals for the conditional

administration of the sacraments: one-half hour to one hour, in the case of death after a lingering illness; and two or even more hours, in the case of sudden death.

Quite obviously it is the mathematical norm expressed in the note's final sentence which has created a seeming conflict between what is medically desirable and what is theologically permissible. In an attempt to resolve that conflict by demonstrating it to be merely apparent rather than real, a couple of preliminary distinctions may be helpful: (1) the distinction between real and apparent medical death; and (2) the further difference between real medical death and what might correctly be called theological death.

MEDICAL DEATH

Real medical death may be defined as the cessation of essential vital function beyond every reasonable hope of resuscitation. This is the notion of death with which doctors as such, regardless of religious convictions or lack of the same, would be most familiar. It is the concept which presumably is verified whenever a patient is pronounced dead by a qualified physician.

The conclusion that medical death has truly occurred in any given instance is a deduction from certain external and perceptible signs, some of which are immediately conclusive, some of which

¹St. Louis: Catholic Hospital Assn., 1959.

provide merely suasive or probable evidence that essential vital function has ceased beyond reasonable hope of revival. If a body, for example, is discovered in an advanced state of decomposition, no reasonable person would doubt about the occurrence of medical death at some considerable time previously. On the other hand, imperceptible pulse or indistinguishable respiration might not of itself provide certitude as to the final cessation of life. It is by no means inconceivable that a person could exhibit any one, or perhaps even several, of this latter type of symptom without being as yet beyond medical hope. In other words, he may be only apparently dead in the medical sense of the term.

Clearly the decision that genuine medical death has or has not as yet occurred is one which is the rightful prerogative of doctors and not of theologians. There are times, of course, when the fact is instantly and unquestionably evident even to the medically unqualified. Suppose, for example, that a steeplejack has his head literally crushed to a pulp as the result of a fall from a high tower. Beyond all conceivable doubt that man was medically dead at the instant of his hitting the ground. But apart from such extremely obvious examples, certain more subtle indications of medical death — signs which might easily escape the medically untrained — may well provide a doctor more or less immediately with indisputable evidence that life has irrevocably ceased. And once that decision

has been properly made, certitude of real medical death has been established in accordance with the meaning of Directive 25.

THEOLOGICAL DEATH

By theological death is understood the separation of soul from body. That this separation does take place, and that it does furthermore constitute the theological essence of death, are rudimentary points of Catholic doctrine. But we do not know (and without divine revelation on the matter we simply can never discover) exactly when the soul departs from the body. Does this dissolution occur instantaneously and concomitantly with medical death, or does the soul linger, as it were, functionless within the body for some time after medical death has taken place?

In the absence of tangible evidence that would establish either one or the other hypothesis as certain, theologians are inclined for several reasons to favor a somewhat delayed separation of soul and body. Consequently they are more than willing to concede an interval of time between the instant of real medical death and the moment of theological death. When the physical phenomenon of dying is itself a protracted thing, they picture the dissolution of soul and body as taking place soon after medical death occurs. Hence the ultimate departure of the soul will perhaps occur within a relatively shorter time after essential vital function has ceased. But when death is a very abrupt transition from robust good health

to definitive lifelessness, the soul's ultimate departure is delayed proportionately.

It is important to realize, however, that the practical implication of a distinction between medical and theological death bears reference primarily, if not exclusively, to the administration of the sacraments. As every Catholic should know, the sacraments may be validly administered only to the living. But if one considers life as the conjunction of body and soul; and if one further admits the possibility that body and soul remain united for an indefinable interval after the occurrence of medical death, there is immediately apparent the justification for our common practice of conferring certain sacraments conditionally even upon some who are most assuredly dead in the medical sense.

DIRECTIVE 25

With the foregoing distinctions in mind, the question of autopsy as initially proposed in this discussion might now be reworded in this fashion: must autopsy be delayed until the physician is morally certain of *theological* death, or does reasonable certitude of *medical* death suffice?

The "real death" to which Directive 25 refers is to be understood as real medical death, i.e., the cessation of essential vital function beyond reasonable hope of resuscitation. As the first sentence in fine print explains, "the main point here is that the physician should be reasonably certain that the subject is not merely apparently dead before he starts the

post-mortem." As a specific application of the generic principle enunciated in Directive 12², this rule on autopsy is simply a reminder to the doctor that post-mortem may not be started while there exists any solid probability that it would induce a positive cause of real medical death in a person who is only apparently dead.

Even on the assumption that several hours may elapse between certain medical death and conjectural theological death, no valid reason can be advanced against the licitness of autopsy which is begun as soon as medical death is morally certain. Just as surgery during life does no irreverence to the patient's soul, so autopsy after medical death is entirely compatible with our duty of reverence in the event that the soul still informs the body. And it would appear to be entirely unsubstantiated to suggest that a post-mortem, consequent upon medical death but prior to theological death, tends to "drive the soul out of the body" sooner than it would otherwise depart.

As implied previously, the Directive's fine-print reference to the "one-half hour to one hour" and the "two or even more hours" lapse of time is a rule-of-thumb devised in order to give us the widest possible latitude in the administration of the sacraments after the subject's death. This mathematical estimate does not apply — nor was it originally inserted in the note as intended to

²"The direct killing of any innocent person . . . is always morally wrong."

apply — to any minimum interval of time which must elapse between morally certain medical death and the inception of autopsy. As Directive 25 itself equivalently says, as soon as death is morally certain, post-mortem may be begun.

Perhaps our unfortunate steeplejack may serve as a posthumous illustration of our theological position regarding medical and theological death as these concepts affect autopsy and the administration of the sacraments. With his head crushed literally to a pulp, the victim is indisputably dead in the medical sense, and consequently a post-mortem could commence immediately since there is not even the semblance of reason to fear that death is merely apparent and that autopsy would induce real death. But the man's soul possibly remains united with that medically dead body for several hours, and therefore the sacraments could be conditionally administered on the strength of the possibility that theological death may not yet have occurred.

SUMMARY

The Note appended to section 25 of *Ethical and Religious Directives for Catholic Hospitals* has apparently occasioned the misconception of some theological neces-

sity for delaying autopsy after ascertainment of death. That this necessity is imaginary and not real can be established by adverting to the distinction between medical and theological death and to the reason for so distinguishing.

"Medical death" refers to the cessation of essential vital function beyond every reasonable hope of resuscitation. The fact of its occurrence is entirely a matter for doctors to decide in accordance with accepted medical norms.

"Theological death," a totally distinct concept, implies the separation of soul from body. Although theologians cannot be certain of the fact, there are suasive reasons for believing that theological death may not occur until some time after medical death. This doctrine has its application in the administration of the sacraments and is not directly of medical concern.

Regardless of the speculative doubt regarding theological death, there is no reason to insist that doctors ascertain anything more than real medical death before commencing autopsy. The "real death" mentioned in Directive 25 is real medical death. The mathematical norm referred to in the final sentence of the Note does not refer to autopsy.

Musings of a Layman ▲ ▲ ▲ ▲

CHARLES E. BERRY, M.S.H.A., LL.B.*

IF YOU WANT to make your patients happy, charge them a fee sufficiently large to provide after-dinner conversation. For some reason, my attempts at small talk fail because I have never been fortunate enough to be what I could honestly state, "victimized" by a physician. Lampooning the medical profession has not only become fashionable, it has become a science. This worries me, a layman whose slight knowledge of medicine is the result of osmosis, rather than any sincere effort to master the art of healing, and yet why should it worry me? What do I have at stake?

Since this is written for a publication geared to physicians, I would be insulting the intelligence of my readers if I intimated that an answer were necessary. Physicians know the answer, hospital personnel know the answer, but does Mr. Average Citizen know too?

May a troubled layman make a suggestion or two?

Organized medicine (admittedly an inaccuracy) has to snap the whip by purging (a despicable word), wherever possible, the increasing number of humorous (to the uninitiated) cartoons which are sensitizing the public through an insidious and subtle type of therapy which in effect pictures the physician as a combination of

Nero and Henry VIII and the public as a much maligned Topsy. The stories and quips with double meanings, the blasé notoriety that erupts when one physician makes a wrong turn are insidious. Your own technique, the power of suggestion, is being used to defame you and your profession.

Perhaps it is unfortunate that most physicians have little contact with the public they serve except when the doctor-patient relationship exists, a relationship not conducive to revealing honest attitudes. Pay a visit one day to the recreation rooms of some of our factories, or neighborhood clubs, thumb through the periodicals available at any airline or railroad newsstand. It might be surprising to see what clippings are posted on the bulletin boards — not obscene, not objectionable to anyone but you; yes, you will always be pictured as the big, bad wolf. Sadly enough, some will be reprints from your own periodicals.

Censorship — no, but counter-attack, yes. Never underestimate the power of the press or the gullibility of the average American.

Why can't physicians get together? I was amused, surprised and stunned, in that order, when the administrator of one of our hospitals informed me that her staff did not want to grant staff membership to either the patholo-

gist or the radiologist although the credentials committee recommended their acceptance. The staff was all for accepting them as department heads and so voted, but did not, apparently, want to accept them as physicians. It seems strange to a lay person that there should be a caste system among doctors, that some are considered technicians, others merely tolerated because they have not concentrated on one phase of medicine, but rather have given full attention to human misery in its totality. In years past, did administrators deny general practitioners the use of their hospitals, prevent radiologists from becoming members of the active staff? — or was it the medical staff that vetoed their acceptance?

To the average professional in other fields, the controversy involving methods of compensation is ludicrous. On my desk at the moment is a news release announcing the opening of a new clinic supported by Mr. Reuther's union. In it the statement is made that 75 full-time physicians will be employed by the clinic. In New Jersey, one of the Assistant District Attorneys has publically announced an investigation into the relationships existing between physicians, specialists, and hospitals. He will probably pursue this if it is politically expedient and if he does an intelligent job, he can get reams of publicity for himself and his party at the expense of both hospitals and physicians. It will be difficult for even the best public relations firm to create a favorable image for men whose salaries run

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into five and six figures after such publicity. The unfortunate aftermath will be the impression that all physicians salaries run into six figures and restrictive legislation will surely follow. Perhaps one remedy would be exchanging the Cadillac for the Rambler as a status symbol.

Psychiatry was dealt a severe blow by the recently publicized talk presented at the A.M.A. meeting held in Miami, Florida in which legalized abortion was suggested. To thousands of Catholics this meant a disregard for any moral code and has created a distrust of this branch of medicine which will inhibit consultation by those who might be helped. But worse than that, it symbolizes the philosophy of medicine in the minds of many.

Why is medicine failing to attract our better young students in adequate numbers to meet the need? Many superficial answers are readily available — cost, time, and others. The real reason is just as apparent if one cares to search for it; the profession, as a profession, has lost its appeal because somewhere, somehow, the idealism, the spirit of service, the man image has been destroyed.

This is the task facing physicians today; the restoration of respect for the practice of medicine based upon service to a community. Physicians represented by any spokesman should declare a moratorium and for one year refrain from supporting any negative report and spend the fees now allocated to lobbying in an effort to acquaint their membership with

the danger of being relegated to the position of civil servants.

It's absurd to oppose loss of autonomy by platitudes instead of correcting the cause. It may be too late to build dikes; perhaps the need now is for boats.

Medicine and its contribution to the health and happiness of every individual is not sufficiently appreciated because no one has taken

the time to advise of the problems involved in practice. The physician is fast becoming a journeyman because no one has explained the intricacies of the profession. The physician must be given autonomy; he must be revered or all humanity suffers. This, it appears to me, is the task facing our County Medical Societies.

*Mr. Berry is Associate Professor in Hospital Administration, St. Louis University, St. Louis, Missouri.



MEMENTO OF OUR PATRON SAINT

An attractive, oval-size, oxidized medal of St. Luke is now available through the National Federation Office. Catholic physicians will want to carry this remembrance of their Patron Saint.

Order now and for distribution to those attending the "White Mass" on October 18.

Write to:

National Federation of Catholic
Physicians' Guilds
1438 So. Grand Blvd.
St. Louis 4, Missouri

Prices: 25c each; 50 for \$10.00; 100 for \$18.00; 500 for \$80.00, and 1000 for \$140.00.

ACTIVITIES OF THE NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

JOE E. HOLOUBEK, M.D.*

IN THE NAME of our president, Dr. Eusebius J. Murphy of Bronx, New York, I wish to extend the greetings of the National Federation of Catholic Physicians' Guilds to all of you attending the IX International Congress of Catholic Doctors. I consider it a privilege to be asked to speak to this group and to bring you a report of the activities of your American colleagues.

The National Federation of Catholic Physicians' Guilds was formulated in 1927 by the late Dr. Richard A. Rendich in Brooklyn, New York, following a retreat for Brooklyn Catholic physicians. The "retreat group" became a "Guild." These physicians practiced in their daily lives the inspiration they had received in the retreat. The movement spread slowly, with the majority of Guilds organizing in eastern United States. It was in 1932 that the various groups were united as one, and the Federation of Catholic Physicians' Guilds was founded.

The objectives of the Federation are:

To uphold the principles of the Catholic faith and morality as related to the science and practice of medicine.

AUGUST, 1960

To assist ecclesiastical authorities in the diffusion of the knowledge of Catholic medical ethics.

To uphold Catholic hospitals in their enforcement of Catholic moral principles in medical practice.

To these others may be added:

To increase the spiritual life of the Catholic doctor.

To make all doctors conscious of their dependence upon God in their daily practice of medicine.

In 1944 the Catholic Hospital Association offered its offices in St. Louis as a permanent location for the national headquarters. Growth was slow. In fact, there were only eleven Guilds in 1948. There were 60 in 1957 and in 1960 there are now 91 affiliated Guilds in the United States, Canada, Puerto Rico, with a total membership of 6,110. (Figure 1 shows the location of the individual Guilds.)

Individual Guilds vary in membership from 600 in Boston to 8 in Sheridan, Wyoming. They may include the Catholic physicians in

*Dr. Holoubek of Shreveport, Louisiana is First Vice-President of the National Federation. As an official delegate to the IX International Congress of Catholic Doctors held in Munich, Germany he gave this address on July 28, 1960.

one county, in an entire city, or an entire diocese. The entire state of Arkansas is covered by one Guild, located in Little Rock. As you see in Figure 2, the State of Louisiana is the most completely organized. There are 8 separate Guilds in the State. Each is located in a central city and the Catholic doctors in the surrounding territory are invited to join their local Guild. The heavily populated areas such as New Orleans and Baton Rouge have large membership. On the other hand, there are only 11 in the large area around Monroe. We have reached the goal of a Guild within 50 miles of the home of every Catholic physician in the State of Louisiana. Other States are also organizing in this manner. Every diocese in the State of New York has a Guild. The goal of every Catholic doctor in America belonging to a Guild is still far from achieved.

We estimate that there are some 35,000 Catholic physicians in our country. In the future, we hope all will be members of their local groups.

National Board

The Board of Delegates of our Federation is composed of elected national officers and one representative from each affiliated Guild. The Board meets twice annually, in the summer during the American Medical Association general convention and again in the winter.

The Linacre Quarterly

The official journal of the National Federation of Catholic Physicians' Guilds is THE LINACRE QUARTERLY. It is devoted to promoting the philosophy and ethics of medical practice. It is in reality a medium to bring together Catholic theology and medical science. The circulation of the May 1960

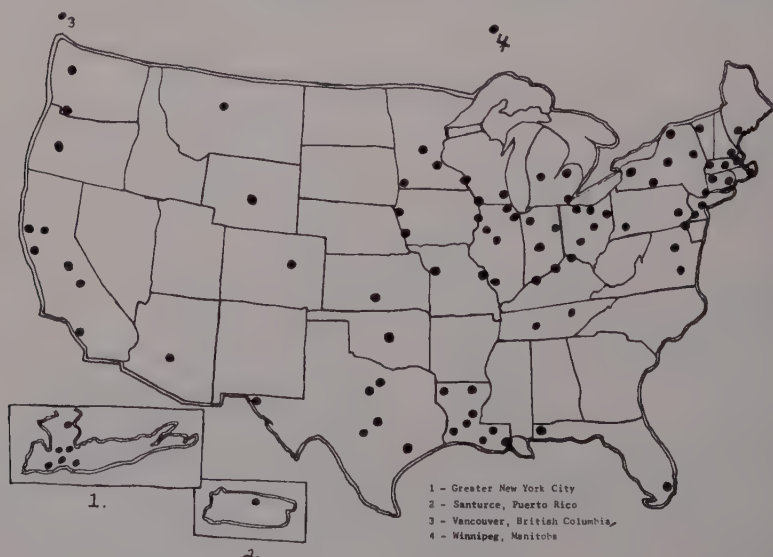


FIGURE 1.

issue was 10,360. It is received by all Guild members. Other subscribers are medical schools, hospital libraries and members of the clergy.

Guilds in Action

Guilds in Action is a newsletter sent to members. It contains a list of activities of the groups, announcements of interest to all members, and a section to help Catholic doctors find locations to practice.

Memorial Mass

A Memorial Mass for all deceased members of the American Medical Association is offered annually during the summer meeting. All officers and delegates of the Association, Catholic physicians

and their families attending the A.M.A. convention are invited to attend. It is usually held at 5:00 p.m. and celebrated by the Moderator of the Federation, presided over by the Bishop of the diocese. Some 550 persons assisted at the Mass in Miami, Florida, June 15 this year.

Federation Exhibit

Since 1956 the Federation has exhibited at the American Medical Association annual convention. The booth has a large display entitled "Moral Principles in Medical Practice." It is staffed by members of Guilds. Copies of *THE LINACRE QUARTERLY* and publications explaining medico-moral principles are distributed. Many hundreds of non-Catholic as well

STATE OF LOUISIANA

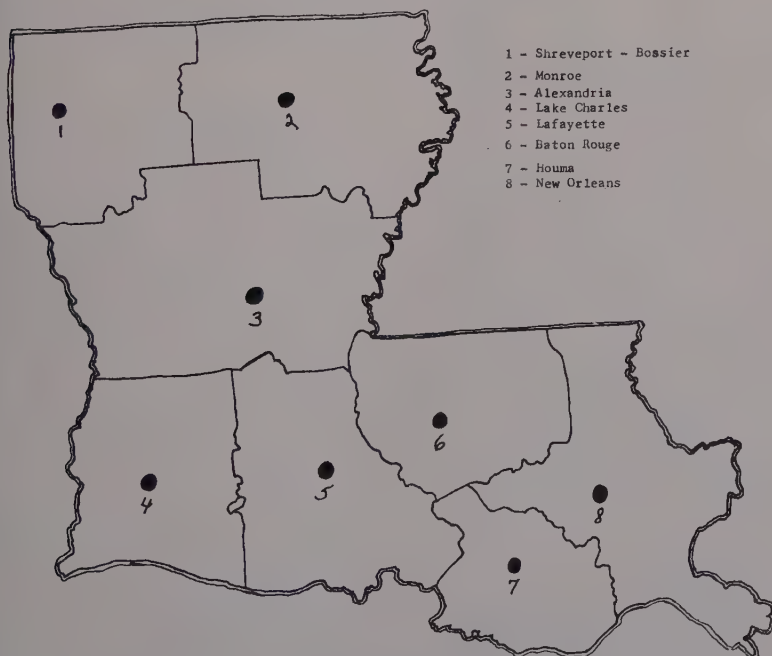


FIGURE 2.

as Catholic physicians visit the exhibit and learn about our beliefs and principles.

Thomas Linacre Award

Periodically, the Thomas Linacre Award is given to the Catholic physician contributing an article to *THE LINACRE QUARTERLY* judged by an editorial board to be most valuable in content to promote the interests of the journal in its efforts to express opinions in the light of Catholic teaching as applied to medical practice. In 1957 Drs. Roy J. Heffernan and William A. Lynch received the Award for their article "Is Therapeutic Abortion Scientifically Justified?" In 1958 it was received by Dr. Eugene G. Laforet for his contribution, "Boxing, Medical and Moral Aspects." An Award will be made to a medical student in the future should worthy contributions be received, to encourage writing in the medico-moral field.

Catholic Physician of the Year

This Award to the Catholic Physician of the Year is presented at the winter meeting of the Federation to a Catholic doctor who is outstanding in his medical and spiritual life. Recipients have been the late Dr. Edward M. Gans, Harlowton, Montana, in 1957; the late Dr. Joseph J. Toland, Jr., of Philadelphia, Pennsylvania, in 1958, and Dr. John J. Masterson of Brooklyn, New York, in 1959.

The White Mass

Since 1954, the Guilds have been urged to celebrate the "White Mass" to honor St. Luke, Patron

of Physicians, on October 18. The Mass is offered in cathedrals, parish churches, and hospital chapels, the choice being local with the sponsoring Guilds. Many Catholic hospitals in areas where there is no active Guild observe the occasion, inviting their medical staffs and hospital personnel to attend.

Silver Jubilee Celebration

The largest social function of the National Federation was the Silver Jubilee celebration held in New York City, June 5, 1957. An anniversary Mass was celebrated at St. Patrick's Cathedral at 9:00 a.m. In the evening a banquet and ball were held at the Waldorf-Astoria Hotel with guests exceeding 1,100. Representatives were present from all of the national medical organizations. General Carlos Romulo of the Philippine Republic addressed the group.

Local Guild Activities

Each Guild is autonomous in its program and organization. Some have monthly meetings; others plan quarterly sessions. Programs are planned to serve the spiritual needs of member physicians.

Retreats are sponsored. All Guild members are encouraged to make one annually.

Days of Recollection are often held in local hospital chapels. These usually begin with 9:00 o'clock Mass on Sunday, followed by three or four spiritual conferences and periods of meditation throughout the day.

A *Requiem Mass* for deceased members of a local group is usually celebrated by the Moderator once

LINACRE QUARTERLY

a year. *Nocturnal Adoration*, *First Friday Communion* and other spiritual activities are sponsored. Enrichment of the spiritual life of the doctor is the primary purpose of these activities. Members are urged to spend a certain period of each day in meditation.

In the State of Louisiana a *Memorial Mass* is celebrated for deceased members of the Louisiana State Medical Society at its annual meeting. Officers and members, Catholic and non-Catholic, are invited to attend. Families of deceased members are sent special invitations. Arrangements for the Mass are taken care of by the Guild in the city where the Medical Society has its annual meeting.

Medical Care Functions

Some Guilds provide medical care to indigent groups, homes for the aged and orphanages. Others supply medical care to large diocesan gatherings where physicians might be needed.

Health Program for Parochial School Children

The New Orleans, Louisiana Guild supplies physicians to examine needy first grade school children. Necessary inoculations are provided. A "healthmobile" for hearing tests, visual, and dental examinations is also sponsored.

Health Program for Religious and Clergy

The requests for help to establish a health-care program for religious and clergy has prompted The Catholic Hospital Association and the National Federation of

Catholic Physicians' Guilds to prepare an examination form for entrance as well as annual check-up which is part of the plan to assist in this area. A pilot project was conducted in the dioceses of Alexandria and New Orleans, Louisiana. Through this program, each religious and priest receives a complete examination with roentgenogram of the chest and necessary laboratory work each year. (Dr. Alice Baker Holoubek discusses the subject in a separate paper.)

Drug Program for the Missions

Several Guilds have organized groups that pick up unused drug samples from physicians' offices and ship them to the foreign missions. More than \$750,000 worth of drug samples have been sent to needy Catholic mission hospitals overseas, through the efforts of the New Orleans, Louisiana Guild. The effort is being extended to include the entire State.

Medical Student Groups

Many Guilds devote special attention to medical students, hospital internes and residents. In some areas they are invited to participate in Guild activities and receive *THE LINACRE QUARTERLY*. Discussion groups for medical students are organized in some areas and regular meetings are held to consider medico-moral principles. Non-Catholic students are invited to attend.

Medico-Moral Problems Institutes

Periodically, meetings with hospital sisters, chaplains, nurses, and physicians are held in various

localities for the discussion of medico-moral problems. Prominent theologians conduct the sessions. Guilds in the area often sponsor a special evening for discussion of specific problems. Courses are given to graduate and student nurses on medical ethics. Other conferences on such topics as hypnosis, moral considerations in radiology, the Catholic physician as a pre-marital counsellor and family counsellor have been among those discussed. Books concerning medico-moral principles are distributed to local hospitals, medical schools and nursing libraries by some of the groups.

Research Grants

Research grants have been supported by some Guilds, to stimulate this activity in Catholic hospitals.

High School Students and Medicine

In some areas, Guilds provide speakers for local Catholic high schools to encourage young men and women to choose medicine as a career.

State-wide Activities

In Louisiana, the officers and Moderators of the eight Guilds in the State have a meeting once a year and discuss their programs and related activities. A newsletter is published monthly and distributed to 400 members throughout the State.

Social Activities

A number of Guilds have dinner meetings to which members' wives

are invited. Speakers discuss topics of mutual interest. Needless to say, cooperation of the spouses is essential for the success of any Guild activity.

Medical Mission Activities

Foreign mission activities are becoming a concern to the National Federation of Catholic Physicians' Guilds as well as to American Catholics. Some Guilds are encouraging programs to familiarize themselves with the medical mission activities of the Church. A few members have gone to mission hospitals to teach and work. Internes and residents are being urged to devote one to three years of their lives in the service of God in the medical missions of His Church. Outstanding among these are the Los Angeles, California Guild that is sponsoring three physicians in the African missions and the Detroit, Michigan Guild that is sending a physician to operate a mission hospital in Guatemala. At the recent summer meeting of the Federation in Miami, Florida a committee was appointed to study methods of correlating medical mission activities of the various Guilds and to develop a program that would promote service in the Catholic mission field.

Needless to say, the activities of the National Federation of Catholic Physicians' Guilds and its various affiliates are varied. However, the basic aim is to bring spiritual counsel and moral guidance to the physician so that he may be a more deeply religious

man and a better Catholic in his daily practice of medicine.

I will close with the *Physician's Prayer* which has been adopted by the Federation:

Divine Healer of the sick, Christ Jesus Our Lord, without whose aid I can do nothing, look down with favor upon me.

Give skill to my hand, clear vision to my mind, kindness and sympathetic understanding to my heart. Give me singleness of purpose, strength to lighten at least a part of the burden of my suffering fellow-men and a true realization of the privilege that is mine. Direct my work that it may be praiseworthy in Thy sight and successful unto those entrusted to my care. Give me the strong and simple faith of a child that I may rely on Thee, and in all things do Thy will. Amen.



PLAN NOW for

THE WHITE MASS

OCTOBER 18, FEAST OF ST. LUKE
PATRON OF PHYSICIANS

ANNUAL MASS OFFERED BY MEMBERS OF THE MEDICAL PROFESSION AND ALL OTHERS DEVOTED TO THE CARE OF THE SICK. HONOR ST. LUKE, PATRON OF PHYSICIANS.





DR. FRANKLYN E. VERDON of Coral Gables, Florida receives congratulations of Father John J. Flanagan, S.J., editor of THE LINACRE QUARTERLY and executive director of The Catholic Hospital Association, following his appointment as Federation secretary. Dr. Verdon is a member of the Miami Guild.



MEMORIAL MASS for all deceased physicians by Msgr. McGowan. A.M.A. officers, Florida non-Catholic physicians heard Bishop Coleman

HIGHLIGHTS

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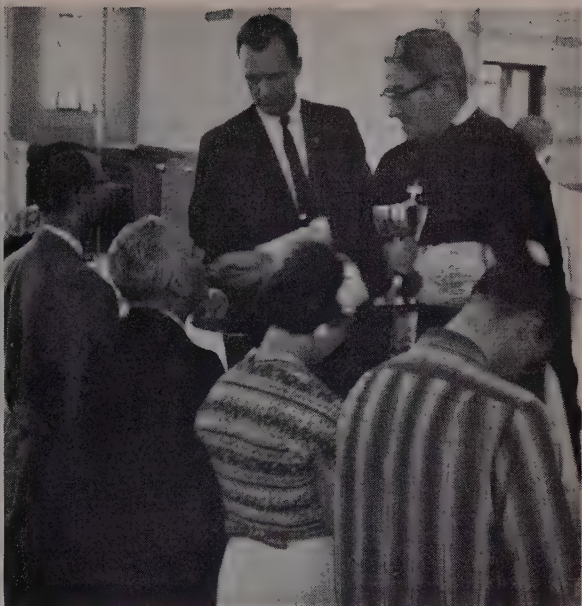
DR. EUSEBIUS J. MURPHY, Bronx, N. Y., national federation president, is shown with Msgr. Donald A. McGowan, the federation's national moderator; Bishop Coleman, F. Carroll of the Miami diocese, and Dr. Edward J. Lauth, Jr., president of the Miami Catholic Physicians' Guild. Photographed at the booth sponsored at the A.M.A. annual convention where the Catholic viewpoint on medical-moral problems was explained to visitors.



DR. J. L. CIRINCIONE, I Albany, New York Guild co discussion during a recess.



ated in St. Patrick Church, Miami Beach, local medical society members, Catholic and the sermon.



MASS SERVERS during Memorial Mass were members of the Miami Guild. Dr. Lauth is shown as he serves Msgr. McGowan, who distributed Holy Communion to physicians and their families.

FEDERATION ACTIVITIES

ORIDA JUNE 13-17, 1960

ion • Executive Board Meeting • Memorial Mass



William Fitzgerald of the McGowan on a point of



GUILD REPRESENTATIVES attending the annual meeting of the national federation executive board meeting, June 15. Dr. Clement P. Cunningham, Rock Island, Ill. and second vice-president of the national organization, is explaining plan for Guild membership drive.

Current Literature: Titles and Abstracts

Material appearing in this column is thought to be of particular interest to the Catholic physician because of its moral, religious, or philosophic content. The medical literature constitutes the primary but not the sole source of such material. In general, abstracts are intended to reflect the substance of the original article. Parenthetical editorial comment may follow the abstract if considered desirable. Books are reviewed rather than summarized. Contributions and comments from readers are invited.

Jeffcote, T.N.A.: Indications for therapeutic abortion, *Brit. Med. J.*, pp. 581-588, Feb. 27, 1960.

Based upon a 10-year experience with 63 cases of therapeutic abortion, the writer estimates that the need for this procedure does not arise more than once in every 1,000 gestations. While underlying principles governing the decision to perform therapeutic abortion remain unchanged, the actual indications are altered by advancing medical knowledge. The number of medical indications has rapidly decreased in recent years, although pulmonary insufficiency has been added as a relatively new reason for advising abortion. Psychiatric indications "are easily abused to justify the removal of an unwanted pregnancy." The author concludes, "Induction of abortion nowadays rarely offers hope of improvement or cure of the patient's disease; it generally aims to do no more than prevent deterioration of the mother's condition and is therefore more often prophylactic than therapeutic."

(Editorial): The smoker and his conscience, *America*, 103:9, April 2, 1960.

There is mounting scientific evidence to show a direct causal link between heavy cigarette smoking and lung cancer. In addition, tobacco is also probably involved in coronary artery disease. Does the heavy smoker have a moral obligation to reduce or stop his smoking? According to Father John C. Ford, S.J., tobacco is one of numerous "chemical comforts" available to satisfy the minor needs of men. In general, there is no problem in the use of such materials. The difficulty arises in deciding what constitutes moderate use. "It is at present impossible to impose . . . a clear obligation" to stop or reduce the use of tobacco. All life is hazardous. "The man who inhales fifty cigarettes today may choke on Friday's sardines. Meanwhile, his judgment on

balancing the comforts of nicotine against the calculated risk of bronchial disaster had better be left between his conscience and his God."

Freeman, W.: Psychosurgery, *American Journal of Psychiatry*, 115:606-607, January, 1959.

Analytically oriented psychiatrists have tended to shy away from the study of lobotomized patients. Eugene Brody, however, reporting on a study of eleven patients before and after anterior lobotomy, finds that the overwhelming aggressive energies mediated by the superego are reduced, and that the ego functions can then be engaged in organized control of objects without destroying them.

The moral problem, discussed by Father Gerald Kelly, S.J. indicated that lobotomy and similar operations are justified when medically indicated as the proper treatment of serious mental illness or of intractable pain, provided the indications are clear and the expected advantages will outweigh the possible evil. In general, he states, good medicine is good morality. In accordance with this, psychosurgery is licit on the basis that the individual can sacrifice a part in the interest of the whole. Rather than being a measure of desperation, lobotomy becomes the turning point in reconstructive therapy. —R.J.C.

Altschule, M. D.: Gresham's Law and debased advertising (editorial), *Medical Science*, 7:627-673, May 25, 1960.

Increasing interest in the ethics of the pharmaceutical industry is reflected in this pertinent editorial which concludes: "It is difficult to understand how pharmaceutical houses, which rigidly insist on the absolute best in their chemical and pharmacologic laboratories, should have sometimes become so careless as to be satisfied with drug-promotion that is not always above reproach. There is at

times a striking contrast between the quality of their products, developed in their excellent laboratories, and the qualities of some of their promotional activities, conceived (or at least condoned) by the sales personnel."

Bihl, J. H.: The effect of pregnancy on hepatolenticular degeneration (Wilson's Disease), *Am. J. Obstet. & Gynec.*, 78: 1182-1188, December, 1959.

A 26 year old woman with advanced hepatolenticular degeneration underwent a successful pregnancy and delivered a healthy full-term infant. Initial symptoms of the disease had been noted in the mother at the age of 17, and 3 years later the diagnosis of Wilson's Disease was established. At the age of 22, the patient's mental condition required commitment. Early in pregnancy there occurred hyperemesis, fever, and impending hepatic coma. Complications responded well to therapy, however, and the patient was delivered at term. Post partum, the remission of Wilson's Disease continued. Hepatic and hematologic findings regressed remarkably and the neurologic symptoms improved considerably. Although urinary copper excretion decreased to normal, the renal manifestations were only slightly improved. There was no change in the mental status or in the Kayser-Fleisher ring.

Donovan, M. J. and O'Hara, E. T.: Sexual function following surgery for ulcerative colitis, *New Eng. J. Med.*, 262:719-720, April 7, 1960.

Of 26 patients treated surgically for ulcerative colitis, 21 had removal of the rectum and constitute the basis of this report. The status of sexual function postoperatively was determined by personal interview. Only 2 patients noted impairment: one, who had undergone a wide resection because of the mistaken diagnosis of carcinoma, was permanently impotent; the other was only partially and temporarily (1 year) impotent. Provided the dissection is performed close to the rectum, there is no reason to fear sexual dysfunction when abdominoperineal resection is done for ulcerative colitis in young men.

Plass, H. F. R.: Childbirth after pneumonectomy, *Minnesota Med.*, 42:1099-1100, August, 1959.

Two young women, each with surgical absence of an entire lung because of bronchiectasis, became pregnant and had uneventful deliveries. The first patient

was delivered normally and remained well during the subsequent 12 years except for 3 episodes of pneumonia in the residual lung. The second patient, who had additional diagnoses of mitral stenosis, emphysema, sinusitis, migraine, and hay fever, was delivered easily by cesarean section under local anesthesia at 36 weeks. Her clinical course during the year following delivery was generally satisfactory.

McKernan, L. (C.S.P.): The population bomb, *Catholic World*, 189:124-129, May, 1959.

"The Population Bomb," a 24-page high-powered pamphlet distributed by the High Moore Fund of New York, purports to be the joint effort of "a group of business, labor, and professional men concerned with the spread of communism in underdeveloped countries." Its avowed aim is to "sell" birth control.

Easy to read and cleverly illustrated, the pamphlet is claimed to be "so persuasive that it might even persuade the Catholics to change their doctrine on birth control." Yet there are certain stubborn facts which have been by-passed by the persuaders. Such bland assertions as "improvement of living standards . . . is impossible without a slowdown in population growth" or that "there is a spreading desire among destitute people everywhere to limit the number of their offspring" are simply stated and not proved. They are, in fact, conclusively refuted by the situation in the East.

The authors of "The Population Bomb" speak quite hopefully of "The Pill" and strongly advocate financial support for the scientific research in this field, but they are silent about the possible effects this discovery might have, especially on the already reduced population of Europe. Unquestionably, Europe and not the underdeveloped countries would feel the greatest effect of "The Pill."

Appealing to the purse strings of the nation, the authors argue that "the United States taxpayers cannot feed the world." Yet at the present time the United States Department of Agriculture is spending a million dollars a day just to store our food surpluses. And if economists can be believed, the world's most serious future problem is food shortage, not population increase.

The totally unwarranted conclusions about the population in the United States prompts the authors of this pamphlet to urge that even in the United States the population problem should be our first

concern. They even suggest that money we are now spending on public health and control of diseases would be better spent on "education" in population control.

Fortunately, physical scientists are much more optimistic about increasing present food production and about harnessing the forces of the sea to feed the underdeveloped countries than are the population planners.

Finally, the authors of "The Population Bomb" take great liberty in interpreting the Roman Catholic Church's adjustment of its teachings to changes in conditions as indicating a future relaxation of her teaching on birth control, and in quoting that "in the most advanced countries of the West, including the United States, current vital statistics reveal birth rates of Catholic communicants quite as low as Protestants." Again, the facts seem to have been by-passed.

One danger is that this controversy will obscure the real problems created by population growth and allow Americans to forget about the clear and present challenge of the Russian economic offensive in Asia. Birth control is not going to "save" the free world from Communism.

— R.J.C.

Millar, J. H. D., Allison, R. S., Cheeseman, E. A., and Merrett, J. D.: *Pregnancy as a factor influencing relapse in disseminated sclerosis*, *Brain*, 82:417-426, (Part 3), 1959.

Of 390 women with a diagnosis of multiple sclerosis, 262 were studied in order to determine a possible relationship between pregnancy and relapse. There appeared to be a higher relapse rate immediately after parturition than occurs at other times in single or married women, suggesting the possibility of a causal association between childbirth and relapse.

[For a related article, cf. Lawyer, T., Jr.: Multiple sclerosis, *Med. Clin. N.A.*, 651-653, May 1958, abstracted in the May 1959 issue of this journal.]

THE NATIONAL CONFERENCE on the Legal Environment of Medical Science, jointly sponsored by the National Society for Medical Research and the University of Chicago, was held in Chicago on May 27-28, 1959. The report of this meeting is now available (National Society for Medical Research, 920 S. Michigan Blvd., Chicago 5, Illinois, 114 pp., paper, \$2.50). These proceedings embody the results of three sessions, all of which contain material of considerable

medico-moral interest. The first session was concerned with the use of cadavers, organ transplants, and autopsy procedure. Animal experimentation was the subject of the second session, while the third dealt with clinical research and included consideration of medical research on human beings and principles involved in the clinical use of investigational drugs. The report should prove of value to a wide spectrum of physicians, particularly those engaged in clinical investigation.

Claman, M. A.: *The surgeon's conscience*, *Surg., Gynec. & Obstet.*, 110:749, June, 1960.

The dramatic concept of the surgeon as somehow different from his non-surgical colleagues has been fostered in the lay mind and has even achieved currency in the profession. Such a "palpably nonsensical" idea should not, however, obscure a valid difference between surgeons and other physicians. The distinction is concerned with the physician's reaction to complications and deaths. When a "medical patient" dies, the internist can assume the common, convenient, and understandable fatalism that the diagnosis and treatment were correct but the patient failed to respond. The death of a surgical patient, on the other hand, prompts in the surgeon severe pangs of conscience and rigorous self-criticism. "The medical man is not immune to these pangs of conscience, nor is the surgeon invariably touched by them. The difference is quantitative and is accounted for by the simple act of operating upon the patient."

[Cf. also: Altemeier, W. A.: *The surgical conscience*, *A.M.A. Arch. Surg.*, 79:167-175, August, 1959, abstracted in the February, 1960 issue of THE LINACRE QUARTERLY.]

THE ENTIRE January-February 1960 issue of CA (volume 10, No. 1, published by the American Cancer Society) is concerned with the management of the patient with incurable malignancy. Various shades of opinion are expressed by the numerous contributors, but in general the tenor is in keeping with Catholic medical ethics. The initial section contains abstracts of 20 pertinent articles on the topic, beginning with an address by Dr. Murray M. Copeland to the entering class at Georgetown University Medical School (Copeland, M. M.: *A vision fair and fortunate*, *Bull. Georgetown Univ. Med. Center*, 9:92-96, January, 1956). The abstract section is followed by an article ("Why Prolong the Life of a Patient with Advanced Cancer?") in which Dr.

David A. Karnofsky adduces several cogent arguments in support of his thesis that it is the doctor's duty to sustain a patient's life as long as possible. The Catholic view-point is expressed in "Prolongation of Life in Terminal Illness," by E. Paul Betowski, S.J., of the Department of Philosophy, Georgetown University. Dr. Paul Chodoff presents "A Psychiatric Approach to the Dying Patient" and Dr. Enoch Callaway concludes the issue with "The Misuse of Narcotics by Patients Suffering from Cancer."

Also indicative of heightened current interest in the care of the patient with malignancy is a symposium from the Mayo Clinic (What shall we tell the cancer patient?, *Proc. Staff Meet. Mayo Clin.*, 35:239-257, May 11, 1960). Contributors include an internist, a surgeon, and a psychiatrist. The results of a survey on the question, "Should you tell a patient he has incurable cancer?", conducted by *New Material Medica*, appear in the March, 1960 issue. Of 5,000 physicians queried, 22 per cent answered an unqualified "Never", 16 per cent "Al-ways", and 62 per cent qualified their reply. Current British views on the problem have been reported by Lister (Lister, J.: Telling the Patient, *New Eng. J. Med.*, 261:1125-1126, November 26, 1959).

Thompson, W. S.: World population and food supply (Report to the Council on Foods and Nutrition, A.M.A.), *J.A.M.A.*, 172:1647-1650, April 9, 1960.

In recent years there have been two principle approaches to the problem of the world's food supply. Those who emphasize the potential increase in world food production see no serious danger of a world food shortage; others who emphasize probable rather than possible increase believe that there is serious danger of such a shortage. However, the real food problem is not whether there will be a world shortage, which is unlikely, but whether localized shortages in such countries as India, China, and Pakistan will produce serious effects in international relations. It is doubtful whether such nations as these can improve their level of nutrition in the face of a population increase of 1.5 to 2.5% per year. This will place heavy pressure on some governments to seek territorial expansion.

Sokal, J. E. and Lessmann, Ellen M.: Effects of cancer chemotherapeutic agents on the human fetus, *J.A.M.A.*, 172: 1765-1771, April 16, 1960.

August, 1960

Pregnancy is not a common complication in cancer and its occurrence does not usually alter therapy. However, pregnant women with disseminated malignant disease occasionally are seen as candidates for palliative chemotherapy. In such instances the possible deleterious effect on the fetus must be considered, since the birth of a living infant with severe congenital abnormalities "would be a tragic blow to a family already suffering under the burden of the impending death of the mother." Animal experimentation has amply demonstrated that many cancer chemotherapeutic agents can cause fetal death or malformation. This has been confirmed clinically although in the human the results appear to be less severe than may have been predicted from the animal experiments. The risk of fetal injury is higher when the chemotherapy is administered in the first trimester and when a combination of agents is used. Regarding specific drugs, aminopterin is both abortifacient and teratogenic. Alternating therapy with busulfan and 6-mercaptopurine produced multiple severe fetal abnormalities when these agents were administered throughout pregnancy, although neither drug alone caused serious fetal damage.

THE SLOW-DYING, oft repeated misconception that the Church prohibited anatomic dissection during the Middle Ages is placed in proper perspective by Hochberg in a recently published work (Hochberg, L. A.: *Thoracic Surgery Before the Twentieth Century*, New York: Vantage Press, 1960. \$15.00). The writer clearly indicates that the edict of the Church was directed against the crusaders' practice of boiling the bones of their deceased colleagues in order to facilitate transportation of the remains to the native land of these individuals (pp. 61-62). Christian doctrine, however, fares less well at the hands of Feldman (Feldman, A. B.: The pattern of promiscuity seen in Schnitzler's "Round Dance," *Psychoanalysis & Psychoanalyt. Rev.*, 47:24-34, Spring, 1960). Referring to a patient as "one of those numerous young women in whose mind sex means sin and true love, illicit love," he states that this conviction is "incidentally a cardinal dogma of Christianity." Except perhaps in the literature of psychoanalysis it is difficult to find support for this gratuitous assertion.

CORRECTION

The following letter has been received from Dr. Miriam G. Wilson, Assistant

Professor of Pediatrics, University of California School of Medicine, Los Angeles, and appears here with her permission:

"Unfortunately your reviewer of February, 1960 did not carefully read our article (Teratogenic effects of Asian influenza, *J.A.M.A.*, 171:638, October 10, 1959). Two major anomalies, anencephaly in both instances, were found in the Asian influenza mothers as compared with a probably genetic anomaly and a questionable myelopathy in the control group. Since small numbers were involved, the difference between the two groups could not be said to be significant. Our conclusion was that our study did not definitely indicate a teratogenic effect of Asian influenza, whereas your reviewer stated that we 'concluded that Asian influenza occurring during pregnancy is not teratogenic'."

The study of Coffey, V. P. and Jessop, W. J. E. (Maternal influenza and congenital deformities, *Lancet*, 2:935, November 28, 1959) found a significant increase (2.5x) of congenital anomalies born to mothers who had a history of Asian influenza in pregnancy compared with mothers without Asian influenza. The most common anomaly in the flu group was anencephaly.

ADDITIONAL significant material:

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CONTRIBUTORS:

R.J.C. (Richard J. Church, S.J.) is a theological student at Alma College, Los Gatos, California. The second contributor is Eugene G. Laforet, M.D., chairman of the committee to prepare these abstracts.

Readers interested in submitting abstracts please send to:

Eugene G. Laforet, M.D.
170 Middlesex Rd.
Chestnut Hill 67, Mass.



MEDICO-MORAL PROBLEMS INSTITUTE

✓ An Institute on Medico-Moral Problems conducted by Reverend John J. Lynch, S.J., Professor of Moral Theology at Weston College, Weston, Massachusetts, will be held November 1-2-3, 1960 at the Roosevelt Hotel, Pittsburgh, Pennsylvania.

Sponsored by The Catholic Hospital Association, the three-day sessions will concern vital topics in the field of medico-morality. Physicians are urged to attend, as well as hospital chaplains, nurses, and sisters in operating rooms and obstetrics departments. Write to Miss Jean Read at the Catholic Hospital Association office, 1438 So. Grand Blvd., St. Louis 4, Missouri for complete program details and application form. Registration fee is \$20.00 for the three days.

Book Review

Counselling the Catholic

George Hagmaier, C.S.P. and Robert Gleason, S.J.

Review by

J. Joseph Hofmann, S.J.
Chaplain, Kings County Hospital
Brooklyn, New York

"Grace builds upon nature" is a commonplace presumption in dogmatic theology. It is for the professional theologian to describe the nature and operations of grace, and it is for the psychologist and psychiatrist to shed light on the intricate and interacting workings of human nature as we live it. The priest in his role of confessor and pastoral guide should be familiar with both of these fields. The area of grace is covered thoroughly in his training in the theological seminary, and, in more recent years, courses in pastoral psychology are also being presented to the seminarians.

This excellent book is for those who were never privileged to have had such a psychology course; or, if they had one, this book is an outstanding one to have on the bookshelf for review and for renewing the proper attitudes about the problem-solving process.

Does the reading and study of this book turn out amateur priest-psychologists? No! It is definitely not intended as such (and for this reason and to avoid casual "spot" references, the authors have chosen to omit an index). The authors aim to present a compendium of practical psychology, a simple outline of fundamental counselling concepts and techniques. It is a certain minimum of information which every priest should have.

Although primarily intended for Catholic priests and seminarians, still parents, teachers, doctors, guidance counsellors, youth workers, psychologists, and psychiatrists may find considerable portions of this material useful.

In addition to excellent chapters on the psychological and moral perspectives of masturbation, homosexuality, and alcoholism, there are three chapters that stand out in the estimation of this reviewer.

The first of these is the chapter that stresses the fundamental principle of all counselling and has an importance that cannot be overstressed: be a listener and show a wholehearted acceptance of the client. Silent listening precludes inadequate or even wrong advice. It allows the client to talk out the problem, which, in some cases, is sufficient to solve the problem because, being crystalized in words, the problem is seen more objectively. This might be a difficult technique for a counsellor to adopt, but it is essential.

The chapter on the "psychology of human weakness" highlights another principle: that in complex human emotional conduct, there are very few "blacks" and "whites" but much "gray." Man's personal problems are not always open to easy and quick solutions. The Ten Commandments are reviewed to show some possible underlying elements that can color the treatment to be given in the confessional or in the parlor. For example: the problem of negligence in religious duties may have its foundation in a disregard for all authority stemming from poor parent-child relationships during youth. The strength of the sex drive, the difficult distinction between "wanting" with the senses and "choosing" with the will, and positive sex education are excellently and constructively presented showing factors and insights frequently overlooked in traditional counselling approaches.

Finally, the treatment of scrupulosity does credit to the authors as they disarmingly show how the traditional approach to this problem is inadequate in the light of present psychological findings. After sympathetically considering the approach of the great counsellors of the past, they gently show a better way to handle the scrupulous person.

Besides a complete and modern bibliography that rates a special word of praise, there is also included a list of referral agencies and facilities to be found in most cities that are available to give professional help to such cases as indicate the need. The list itemizes such groups as those concerned with the aged, the alcoholic, labor, legal aid, the Negro, veterans, welfare, young adults, and many others.

The authors modestly contend that their book is only a beginning in clarifying and refining the science and art of pastoral counselling. This volume sets a standard of excellence which may profitably be emulated by subsequent writers in this field.

Counselling the Catholic

Published by
Sheed and Ward
64 University Place
New York, N.Y.
1959 — \$4.50

MINUTES ANNUAL MEETING

EXECUTIVE BOARD

National Federation of Catholic Physicians' Guilds

JUNE 15, 1960

SEVILLE HOTEL

MIAMI BEACH, FLORIDA

ROLL CALL

Officers present

EUSEBIUS J. MURPHY, M.D. — President
JOSEPH E. HOLOUBEK, M.D. — First Vice-President
CLEMENT P. CUNNINGHAM, M.D. — Second Vice-President
GERARD P. J. GRIFFIN, M.D. — Third Vice-President
FRED M. TAYLOR, M.D. — Treasurer

Affiliated Guilds represented

CHARLES W. WESTERBECK, M.D. — Los Angeles, California
S. PAUL TOMBARI, M.D. — Norwich, Connecticut
EDWARD J. LAUTH, M.D. — Miami, Florida
EDWIN J. CASEY, M.D. — Belleville, Illinois
NICHOLAS P. PRIMIANO, M.D. — Joliet, Illinois
STEPHEN C. MICHAELIS, M.D. — Fort Wayne, Indiana
JAMES T. NIX, M.D. — New Orleans, Louisiana
FRANCIS W. DRINAN, M.D. — Boston, Massachusetts
SHEFFICK J. MOROUN, M.D. — Detroit, Michigan
ROY V. BOEDEKER, M.D. — St. Louis, Missouri
J. L. CIRINCIONE, M.D. — Albany, New York
MARTIN F. MCGOWAN, M.D. — Bronx, New York
GERARD P. J. GRIFFIN, M.D. — Brooklyn, New York
WILLIAM P. RILEY, M.D. — Queens, New York
JAMES CORCORAN, M.D. — Rockville Centre, New York
MARTIN J. HEALY, M.D. — Westchester, New York
CHARLES S. BLASE, M.D. — Cincinnati, Ohio
MELVIN F. YEIP, M.D. — Cleveland, Ohio
FRANK E. DARROW, M.D. — Oklahoma City, Oklahoma
BERNARD J. HOUSTON, M.D. — Philadelphia, Pa. (Rene Goupil Guild)
JOHN F. McVEY, M.D. — Pittsburgh, Pennsylvania
STEPHEN FOOTE, M.D. — Houston, Texas
JOHN SATORY, M.D. — LaCrosse, Wisconsin

Others

RT. REV. MSGR. D. A. MCGOWAN — Federation Moderator
REV. JOHN J. FLANAGAN, S.J. — Editor, *The Linacre Quarterly*
MR. M. R. KNEIFL — Consultant
MISS JEAN READ — Executive Secretary
DANIEL A. MULVIHILL, M.D. — Honorary President
JOHN J. MASTERSON, M.D. — Past President
WILLIAM P. CHESTER, M.D. — Past President
FRANKLYN E. VERDON, M.D. — Miami, Fla. Guild
REV. EDWARD L. O'MALLEY — Moderator, Albany Guild
WM. FITZGERALD, M.D. — Albany Guild
VERY REV. MSGR. JOHN C. STAUNTON — Moderator, Cincinnati Guild
HERBERT RATNER, M.D. — Chicago Guild
ROBERT P. LOCEY, M.D. — Ann Arbor, Michigan
C. J. MATERNOWSKI, M.D. — Ann Arbor, Michigan

Sessions of the National Federation Executive Board convened at 9:30 a.m. on Wednesday, June 15, 1960, with reading of the minutes of the Winter Meeting held in Dallas, Texas, December 5, 1959.

PRESIDENT'S REPORT

Dr. Murphy reported on new Guilds, advising of the affiliation of groups in Bakersfield and Fresno in California; Joliet, Illinois; Houma, Louisiana, and Cincinnati, Ohio, since the first of the year.

The president participated in a panel discussion on pornography, sponsored by the Albany, New York Guild. He also addressed the Medical Society of Brooklyn on the occasion of honoring Dr. John J. Masterson as Catholic Physician of the Year for 1959.

Answering a large volume of correspondence occupied considerable time during the past few months.

Dr. Edwin J. Lauth, Jr., president of the Miami Guild, and his planning committee, were commended for their excellent work in behalf of the Federation and its activities as part of the A.M.A. convention and the Memorial Mass.

In behalf of Dr. William Egan of Boston, immediate past-president, who could not be present, Dr. Francis W. Drinan of that city's Guild, received a scroll from Dr. Murphy expressing the gratitude of the national organization for his outstanding service and leadership during his term of office.

It was reported that there are nun-physicians in many missionary

lands. Names and addresses are now available for mailing purposes.

The procedure for nominating candidates for Catholic Physician of the Year was again outlined. Guilds are urged to send in their nominations at once. Biographical material must accompany each name. A nominee must be a Catholic and his name must clear through the local Chancery office; the candidate need not be a member of a Guild.

MODERATOR'S REPORT

Monsignor McGowan advised of a prospective Guild in the area of Lincoln, Nebraska. In the foreign field, it was advised that Lima, Peru has a Catholic Physicians' Guild.

He suggested the appointment of Drs. Joseph and Alice Holoubek as official delegates of the Federation to the International Congress of Catholic Doctors to be held in Munich, July 27-August 3.

Monsignor McGowan commented on the material published in an issue of *Time* magazine concerning Dr. John Rock who is doing research on a birth control pill at Harvard University, reply to which appeared in news releases from the National Catholic Welfare Conference and published in the May 1960 issue of *THE LINACRE QUARTERLY*.

It is the Moderator's feeling that the time has now come for the Federation to support mission projects, assisting in programs to send Catholic doctors to foreign lands, thus providing a medical apostolate for the Church.

THE LINACRE QUARTERLY REPORT

It was reported that the distribution of the May, 1960 issue of the journal totaled 10,367. Circulation includes readers among the membership of Physicians' Guilds totaling 6,100; the balance reaches hospitals, libraries, teachers, students, and physicians who are not members of Guilds.

Material for publication is in continual demand. Articles of significance in the Catholic medical apostolate and that will help direct the future of medicine are highly desired. The journal is the official organ of the Federation and because of its unique nature, the Guilds are urged to encourage their members to submit material for publication.

MEMBERSHIP REPORT

Report was made of 12 new Guilds since the last annual meeting. The following States do not have Guilds: Alaska, Georgia, Hawaii, Idaho, Maryland, Mississippi, Nevada, Utah, New Jersey, North Carolina, North Dakota, Rhode Island, South Carolina and Washington, D.C.

Dr. Clement Cunningham, membership chairman, advised of a plan to have State representatives organize Guilds in their own areas. He pointed out that the largest Catholic population in the United States is east of the Mississippi river and north of the State of Ohio. The State of Louisiana has the nation's largest Catholic population; the diocese of Lafayette is 61% Catholic. It is estimated that there are some 35,000 Catholic physicians in America.

It was recommended to contact local Pastors for the names of Catholic physicians in parishes for prospective memberships in Guilds.

Advertising in diocesan newspapers and the *A.M.A. News* are other sources of promotion.

All the dioceses of the State of New York have Guilds.

Delegates to the meeting were urged to take back the missionary ideal of more Guilds in their areas.

FEDERATION EXHIBIT

Dr. Franklyn E. Verdon of the Miami Guild reported to the Board regarding the Federation Exhibit at the A.M.A. convention, advising that 24 local physicians and medical students, along with 8 or 10 visiting Guild representatives alternated time every two hours to greet those attending the exhibits of the general convention. Dr. Lauth wished special commendation for the assistance of Dr. Verdon, Drs. J. Gerard Converse, Charles Schwartz, Robert J. Boucek, and Scotti as contact committee both for the Federation booth and the details of the Memorial Mass held at St. Patrick's Church.

Reports, copies of *THE LINACRE QUARTERLY*, medals of St. Luke, and other items of interest were distributed to those inquiring about the activities of Catholic Physicians' Guilds. The display caption "Moral Principles in Medical Practice" evinces interest on the part of visitors to the booth and material is available on many topics in this field. Some 260 visitors signed registration cards and many

LINACRE QUARTERLY

requested further information on subjects in their own specialties.

Dr. Gerard P. J. Griffin, general chairman of the Federation booth, suggested that the format be changed somewhat for the future. The same display has been used for five years and to meet current trends in approach, it is felt that a change is in order. Investigation will be made and reported at the Winter meeting of the Federation.

DELEGATES TO INTERNATIONAL CONGRESS OF CATHOLIC DOCTORS

The President appointed Drs. Joseph and Alice Holoubek of Shreveport, Louisiana and Dr. John Muccigrosso of the Westchester, N.Y. Guild as the official delegates of the Federation to the International Congress of Catholic Doctors to be held in Munich, July 27-August 3. Dr. Joseph Holoubek will present a paper concerning the activities of the National Federation and Dr. Alice Holoubek will address the group concerning the health care of priests and religious.

HEALTH OF RELIGIOUS PROGRAM

Pursuing the Program as set forth in the minutes of the 1959 Winter Federation Executive Board meeting, the need for a health care program for religious was again explained. A committee had been appointed to adopt a Medical Examination for Religious form and a pilot project was launched in Louisiana, report of which was to be given at the June meeting. Dr. J. T. Nix of New Orleans, chairman of the committee, reported use of the medical

form in that archdiocese. Members of the New Orleans Physicians' Guild are assisting in examinations. The Program is in progress with the permission of the Ordinary. In the diocese of Lafayette, it is a missionary project, also endorsed by the Bishop. All religious in the diocese have received the medical form. There are 200 doctors in the area of whom 5 are Catholic physicians. Many of the former are assisting in the project. It is felt that this Program will be of great benefit to hospital religious. Further material will be available to Higher Superiors at a later date. Topics of discussion included the transfer of medical records and hospitalization for religious. Further progress report will be made at the winter meeting of the Federation Board.

WINTER MEETING OF EXECUTIVE BOARD

The winter meeting of the Executive Board will be held in Washington, D.C. The dates are December 3-4, 1960.

FINANCIAL REPORT

An audited statement of cash receipts and disbursements for 1959 was submitted to the Board and read by Dr. Fred Taylor, Federation treasurer. It is published in the August, 1960 issue of THE LINACRE QUARTERLY.

FEDERATION SECRETARY

To fill the office of Secretary of the National Federation, vacated by the resignation of Dr. Robert M. Eiben of Cleveland, Ohio, Dr. Franklyn E. Verdon of the Miami,

Florida Guild was elected to the post.

COMMITTEE FOR CATHOLIC PHYSICIAN OF THE YEAR

Dr. John J. Masterson of Brooklyn, New York, Catholic Physician of the Year for 1959, was presented with a certificate to honor him in this title.

Dr. Murphy advised that eight candidates had been named as of June 15 for this year's Award. He asked the Active and Honorary Officers, Monsignor McGowan, and Reverend John J. Flanagan, S.J. to serve as judges. The Award will be made during the winter Executive Board meeting. Dr. Fred Taylor was asked to serve as chairman of the committee.

NEW BUSINESS

Dr. Martin J. Healy, of the Westchester, New York Guild, proposed that the National Federation sponsor a social function in the nature of a dinner dance in New York City when the American Medical Association convention convenes there next June. The Guilds in that area would take responsibility for the plans. The Executive Board agreed, appointing Dr. Healy as general chairman. It was moved to advance \$500.00 to the committee for initial preparations and to guarantee \$2,500.00 of expenses.

Drs. C. J. Maternowski and Robert P. Locey of the Detroit Guild addressed the Board concerning a plan for assisting Catholic physicians interested in serving the Church as doctors in the missions. Efforts in the health care

of Puerto Rican population in the Detroit area had prompted a movement to inaugurate an International Catholic Medical Service. The group working on the project is desirous of the support of the National Federation. With ecclesiastical permission, a central office with a secretary, and typing help, steps can be taken to initiate this important mission service. Dr. Charles Westerbeck of the Los Angeles Guild described the Mission Doctors Association in that area of California that has the approbation of Rome as well as local permission and has been functioning since early this year.

After discussion, the following resolution was proposed by Dr. Daniel Mulvihill of New York and passed by the Federation Board:

Whereas:

It has been called to the attention of the Executive Board of the National Federation of Catholic Physicians' Guilds that there is widespread interest among Catholic lay doctors in the United States to participate personally and actively in medical mission work in the Catholic Foreign Missions,

and, it appears that at the present time there is in the United States no centralized organization for the collection and dissemination of information on such projects, nor for direct liaison between such interested parties and the ecclesiastical authorities responsible for the foreign missions, and
Whereas:

The Detroit constituent Guild has petitioned the Executive Board of the National Federation to consider the establishment of such a central medical bureau with ecclesiastical permission and under National Federation auspices, and this petition has the support of the Los Angeles, and other constituent Guilds of the National Foundation *Therefore, be it resolved:*

1. That the Executive Board of the National Federation of Catholic Physicians' Guilds at its annual meeting of June 15, 1960 express its high commendation to the Detroit and Los Angeles Guilds, and to the individual Catholic doctors concerned for their apostolic zeal in this important field of Catholic mission endeavor, and its unqualified support of their aims and efforts and

2. That the Executive Board appoint a study committee to consist of:

Rt. Rev. Monsignor Donald A. McGowan, Moderator, Washington, D.C.

Reverend John J. Flanagan, S.J., St. Louis, Mo.

Reverend Edward L. O'Malley, Albany, N.Y.

An Officer of the National Federation

A Representative of the Detroit Guild

A Representative of the Los Angeles Guild

A Representative of the Albany Guild

and to empower the President to expand this committee at his discretion.

AUGUST, 1960

This committee to thoroughly investigate and explore:

1. The need for and feasibility of a central medical bureau under National Federation auspices to act as an information center and liaison body between interested lay medical personnel and the ecclesiastical authorities in direct charge of foreign mission work;

2. The specific organizational, personnel, and financial requirements for establishing such a bureau under National Federation auspices;

3. The interest of each of the constituent Guilds, and the general membership of the Catholic Physicians' Guilds in promoting and supporting such an endeavor by the National Federation.

This committee to make a preliminary report to the Executive Board at the semi-annual meeting, December 3-4, 1960, and to continue its activities and report to the Executive Board until such time as information and consideration warrant taking definitive action on the proposals of the Detroit, Los Angeles, and other constituent Guilds.

It was voted, also, to appropriate \$1,000.00 toward initial needs of the plan.

The committee authorized was appointed by the President.

The subject of pornography was presented by Dr. William P. Riley, President of the Queens, New York Guild. Describing the appalling quantity and quality of indecent literature that is distributed daily and falling into the hands of teen-agers, he advised of the work

being done by the *Citizens for Decent Literature Committee* in arousing opinion nationally to the dangers involved for the youth of America. After a thorough accounting of this worthy group's activities, the following resolution proposed by Dr. Mulvihill was passed by the Board:

Whereas:

It has been brought to the attention of the Executive Board of the National Federation of Catholic Physicians' Guilds at its annual meeting of June 15, 1960 by Dr. William P. Riley of the Queens Guild:

That the unrestricted distribution of obscene, indecent, and pornographic literature, photographs, films, etc. constitutes a grave moral problem to the youth of many parts of the United States today, and

That there are Federal and State laws in most areas, which if adequately enforced could stop this nefarious traffic, and

That an aroused and militant public opinion is necessary to stimulate and encourage such adequate enforcement of existing laws by the enforcement agencies of the various Federal and State governments responsible, and

That *Citizens for Decent Literature* is a trustworthy, non-sectarian, non-political organization dedicated to arousing the public opinion necessary for more adequate enforcement of these laws,
Be it Resolved:

That the Executive Board of the National Federation of Catholic Physicians' Guilds at its meeting of June 15, 1960:

1. Endorse and highly commend the efforts of the *Citizens for Decent Literature* for its efforts to arouse a public demand for enforcement of laws for the suppression of distribution and traffic in obscene, indecent, and pornographic literature, photographs, films, etc. and pledge its support to the furtherance of such worthy efforts, and

2. Take definite steps to appraise all the constituent Guilds of the Federation, and the individual members of the Catholic Physicians' Guilds of the enormity and moral implications of this traffic, through THE LINACRE QUARTERLY and other available means, and endeavor to enlist their individual and collective support in behalf of the crusade for decency in literature by the *Citizens for Decent Literature*.

3. That any definite action by any constituent Guild in behalf of this effort be done only after clearance and approval by the Ordinary of the diocese in which that Guild is located.

4. That the Federation express its thanks to and praise of Dr. William P. Riley of the Queens Guild for his personal contributions to this decency crusade in the New York metropolitan area for the protection of the youth of our nation.

THE LINACRE QUARTERLY will be supplied with further data to inform the public how assistance can be given to this campaign against indecent literature.

The Board meeting adjourned at 1:45 p.m.

LINACRE QUARTERLY

NATIONAL FEDERATION OF CATHOLIC PHYSICIANS' GUILDS

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS FOR THE YEAR ENDED DECEMBER 31, 1959*

CASH BALANCE — JANUARY 1, 1959..... \$ 9,986.15

RECEIPTS

Subscriptions —

Doctors	\$ 3,063.25	
Hospitals	2,144.22	
Priests	2,607.40	
Others	1,005.78	\$ 8,820.65
Memberships		11,101.65
Affiliation fees		5,180.00
Meeting income		507.50
Miscellaneous		423.72
Total Receipts for Year		26,033.52
		\$36,019.67

DISBURSEMENTS

LINACRE QUARTERLY printing	\$ 7,996.91
Honoraria	405.00
Reprints	619.05
Advertising	238.40
Stationery and supplies	844.15
Salaries	8,740.00
Postage	790.73
Travel	775.24
Convention exhibit	1,479.02
Board meetings	2,995.80
Returned checks	22.00
Bank charges25
Donations	100.00
Miscellaneous	484.15
Total Disbursements for Year	\$25,490.70

CASH BALANCE — DECEMBER 31, 1959..... \$10,528.97

Accounts payable — December 31, 1959..... \$ 455.75

CASH BALANCE — MAY 31, 1960..... \$18,039.25

ACCTS. PAYABLE — MAY 31, 1960 (Estimated)..... 5,403.72

On Hand May 31, 1960..... \$12,635.53

*1959 Report on Accounts prepared by Kerber, Eck & Braeckel, St. Louis, Mo.,
Certified Public Accountants.

AUGUST, 1960

Roll Call

CATHOLIC PHYSICIANS' GUILDS

The listing below gives the name of the president and moderator of each Catholic Physicians' Guild affiliated with the Federation. These groups constitute the national organization.

ALABAMA

Mobile

President

CHARLES D. TERRY, M.D.
726 Fulton Avenue

Moderator

REV. F. H. YANCEY, S.J.

ARIZONA

Phoenix

DALE H. STANNARD, M.D.
550 West Thomas

REV. JOHN P. DORAN

CALIFORNIA

Bakersfield

PHILLIPS DUNFORD, M.D.
614 Bernard St.

VERY REV. MSGR. ROGER McCANN

Fresno

GEORGE G. WOLF, M.D.
3004 N. Fresno St.

RT. REV. MSGR. JOHN F. DURKIN

Los Angeles

FREDERICK K. AMERONGEN, M.D.
10628 Riverside Drive
No. Hollywood, California

RT. REV. MSGR. J. J. TRUXAW

Oakland (East Bay)

THOMAS H. MCGUIRE, D.D.S.
1904 Franklin St.
Oakland

RT. REV. WILLIAM F. REILLY

Sacramento

NORBERT B. FREY, M.D.
3029 El Camino Ave.

RT. REV. MSGR. THOMAS MARKHAM

COLORADO

Denver

JAMES C. OWENS, M.D.
4200 E. 9th Ave.

VERY REV. MSGR. DAVID MALONEY

CONNECTICUT

New Haven

LUCA CELENTANO, M.D.
115 Howe St.

REV. JOHN C. KNOTT

Norwich

MARIO ALBAMONTI, M.D.
46 Rockwell St.

RT. REV. MSGR. JOHN J. REILLY, V.G.

Stamford

ANGELO MASTRANGELO, JR., M.D.
19 Grandview Ave.

RT. REV. MSGR. N. P. COLEMAN

DELAWARE

Wilmington

JOSEPH J. DAVOLOS, M.D.
1301 Pennsylvania Ave.

REV. THOMAS J. REESE

FLORIDA

Miami

EDWARD J. LAUTH, JR., M.D.
2121 Biscayne Blvd.

REV. JAMES J. WALSH

ILLINOIS

Belleville

JULIAN N. BUSER, M.D.
4601 State St.
E. St. Louis, Illinois

REV. CLEMENT G. SCHINDLER

Joliet

NICHOLAS P. PRIMIANO, M.D.
700 Western Ave.

RT. REV. MSGR. EDWIN V. HOOVER

Peoria

WILLIAM F. CHAMBERS, M.D.
306 Cass

REV. WALTER BUCHE

Rock Island

THOMAS W. CARTER, M.D.
1630 5th Ave.
Moline, Illinois

REV. JOHN O'CONNOR

INDIANA

Evansville

OWEN L. SLAUGHTER, M.D.
Medical Arts Bldg.

RT. REV. MSGR. THOS. J. CLARK

Fort Wayne

STEPHEN C. MICHAELIS, M.D.
1255 Korte Lane

REV. ALBERT SENN, O.F.M.

Hammond

THOMAS C. TYRRELL, M.D.
800 State Line
Calumet City, Illinois

REV. ROBERT EMMONS

Indianapolis

JOHN M. COURTNEY, M.D.
4304 No. Park Ave.

VERY REV. JAMES P. GALVAN

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The Catholic Physicians' Guilds of Bakersfield and Fresno in California; Joliet, Illinois; Houma (Terrebonne), Louisiana, and Cincinnati, Ohio have joined the national organization since the last printing of this Roll Call. Congratulations and best wishes are extended for success in all their endeavors.

